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9/8/88

Vol. 63 No. 9 September 1988

JOURNAL OF Medical Education

PUBLICATION OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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Animals and Alternatives in Medical Education (Editorial)
Edward J. Quilligan

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Volume 63 • Number 9 • September 1988

Home Care Services as Teaching Sites for Geriatrics in Family Medicine Residencies—Edgardo Laguillo 667

An Assessment Instrument To Measure Physicians' Knowledge of Diabetes Management—Karen S. Flavin and James R. Gavin III 675

Correlates of Burnout Among Family Practice Residents—Jeanne P. Lemkau, Richard R. Purdy, James P. Rafferty, and John R. Rudisill 682

Residents' Perceptions of the Effects of a Practice Plan on Their Training—David C. Anderson, Ilene B. Harris, and Alvin L. Schultz 692

A Year-Long Clerkship in Ambulatory Care—Thomas J. Ruane 699

A Controlled Experiment with a Medical Student Honor System—Frederick S. Sierles, Brad D. Kushner, and Philip B. Krause 705

Obstetric Patients' Assessment of Medical Students' Role in Their Care—Diane Magrane 713

Communications: Use of and Alternatives to Animals in Laboratory Courses at U.S. Medical Schools—Neal D. Barnard, Jeffrey Stolz, and Liza Baron 720

A Health Promotion Program for Medical Students—George R. Parkerson, Jr., Howard J. Eisenson, Katharine A. Munning, J. Lloyd Michener, and Michael J. Helms 722

A Method To Calculate and Analyze Residents' Evaluations by Using a Microcomputer Data-Base Management System—Myron L. Mills 724

A Survey of AIDS Patients Regarding Their Experiences with Physicians—Ronald O. Valdisseri, Geraldine Maiatico Tama, and Monto Ho 726

Teaching Medical Students To Do Bibliographic Searching—Jonathan E. Rodnick, Steven M. Simrin, Michael G. Yang, and David F. Altman 728

Editorial: Animals and Alternatives in Medical Education 731

Letters to the Editor 732

Bibliography 734

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Summary of New Instructions for Submitting Articles to *Academic Medicine*

(the retitled, redesigned *Journal* beginning in January 1989)

Academic Medicine will contain both peer-reviewed and non-peer-reviewed articles. Non-peer-reviewed articles will be accepted in three categories: major articles and essays, short opinion pieces, and letters to the editor.

Complete instructions for submitting articles will be published in the October 1988 and January 1989 issues. The following summary of these instructions gives general information for authors submitting articles for the peer-reviewed section of *Academic Medicine*.

Categories of peer-reviewed articles. *Academic Medicine* will have three types of peer-reviewed articles: major articles, short articles, and research notes.

1. Major articles should have no more than 15 standard double-spaced pages of typed manuscript text, 15 references (30 for literature reviews), and five tables or figures. It should have an abstract of 100–150 words.
2. Short articles should have no more than four standard double-spaced pages of text with no figures or tables, or three pages plus one figure or table, and no more than 10 references. It should have an abstract of no more than 100 words.
3. A research note should be 250 words in length (one double-spaced page) and have no reference list, figure, or table (one or two references may be cited in full in the text).

How to submit manuscripts. Manuscripts are considered with the understanding that they are not under consideration elsewhere and have not been previously published. Short abstracts of preliminary research reports presented at conferences and included in conference proceedings do not constitute previous publications; however, presentations longer than an abstract may disqualify the paper.

Papers are reviewed by specialist reviewers, the editor, and occasionally by consulting editors or members of the Editorial Board. All manuscripts will be edited critically by the editorial staff, and the authors must proofread and approve galley proofs.

All authors of accepted papers must assign copyright of the article to the Association of American Medical Colleges and must sign a statement of authorship.

To submit a manuscript, send the following:

1. Two copies of the manuscript
2. A cover letter (signed by the first author or designated corresponding author) stating that the paper has not been previously published and is not under consideration by another journal and noting any inclusion of abstracts or portions of the paper in conference proceedings or similar monographs.

Format and references. Prepare the following materials:

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3. Text. It may be written in first or third person.
4. Tables and figures. Each should appear on a separate sheet and have a descriptive legend that will make the figure or table clearly understandable independent of the text.
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The *Journal of Medical Education* (ISSN 0022-2577) is owned and published monthly by the Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, and printed at Waverly Press, Inc., Mt. Royal and Guilford Aves., Baltimore, Maryland 21202. Second-class postage paid at Washington, D.C., and additional mailing offices.

Subscription Rates: $30.00 per year; $5.00 per single copy; students, $25.00 per year; foreign, $40.00 per year, $6.00 per single copy; Latin America and Canada, $30.00 per year.

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Home Care Services as Teaching Sites For Geriatrics in Family Medicine Residencies

Edgardo Laguillo, M.D.

Abstract—Evaluating the physical and psychological constitution of elderly patients and their social and cultural environments requires skills that should be taught to all physicians in training. A survey was conducted among all accredited U.S. residency programs in family medicine to examine training in geriatrics. The teaching sites most commonly used by the responding programs were the family practice center (used by 96.4 percent), nursing home (81.9 percent), family medicine inpatient ward (62.4 percent), and home care service (HCS) (48.2 percent). The professional most frequently in contact with the resident during training at an HCS was the attending physician. Longitudinal rotations (that is, long-term rotations involving part of each week for months or years) in geriatrics were used more often than block rotations. The HCS rotations ranked highest in residents' evaluations were those in which the resident followed patients long-term and discussed problems and management with a multidisciplinary team. A combined rotation involving a family practice center, a family medicine inpatient ward, and a home care service is discussed as an alternative method of teaching geriatrics in family medicine.

In the coming decades an increasing proportion of the U.S. population will be aged 65 years and older. This shift in the demographic distribution will result in increased demands for inpatient, long-term care and community services for the elderly in all nations (1), and additional medical manpower will be needed to meet the needs of this growing segment of the population (2). In order to achieve the proposed goal of providing higher quality of care in a cost effective manner, teaching programs must face up to the task of educating more and better trained professionals to provide for the needs of the elderly (3).

The need to incorporate geriatrics and gerontology into the curriculum of family practice and other primary care specialties has been well documented (4–8). It has also been clearly stated that long-term care facilities in the community (such as nursing homes, seniors centers, seniors housing projects, and home care services) should all be training settings for geriatrics (1, 11). The advantages of teaching trainees about the delivery of health care in patients' homes have been pointed out (9), yet there has been little or no initiative from educators and program directors of primary care specialties to incorporate formally home care skills and knowledge into their trainees' education (10). Fur-

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thermore, integrating teaching programs with home care units in an effort to develop a working model for service, teaching, and research has been overlooked.

Methods

A survey was conducted of all 380 residency programs in family medicine accredited by the Accreditation Council for Graduate Medical Education. A questionnaire was mailed to the programs in January 1987, followed by a second request to nonrespondents six weeks later. The questionnaire was especially designed for this study and addressed issues such as characteristics of geriatrics training, teaching sites used for geriatrics, and amount of time residents spend in these sites.

All questionnaires received before May 15, 1987, were included in the analysis reported here. The investigation was conducted to examine the integration of home care services (HCS) into geriatrics curricula in family medicine. A home care service is a freestanding, government-sponsored or hospital-based organization that provides equipment and services for medical or social support to patients in their place of residence.

In order to focus upon HCS, specific items were included in the questionnaire on the amount of time the resident spends in the HCS as compared with other teaching sites, professionals in direct contact with the trainee, reasons for including HCS as teaching sites, and evaluations of the HCS experience.

Results

Of a total of 380 programs, 282 (74.2 percent) responded: community-based programs, 188 (67 percent); university-based programs, 62 (22 percent); freestanding programs, 20 (7 percent); and military programs, 12 (4 percent).

The respondents were asked whether their geriatrics programs used longitudinal rotations, block rotations or a combination of both. (Longitudinal rotations involve part of a week for several months or the entire residency; block rotations involve the resident's time for a short period, such as a few days or weeks.) The responses showed that 140 (49.6 percent) of the programs used longitudinal rotations for geriatrics training, 24 (8.5 percent) used block rotations, and 109 (38.6 percent) used both.

Of all the respondents, 147 (52.1 percent) reported devoting from 200 to 400 hours to teaching geriatrics throughout the three years of training, 92 (32.6 percent) spent 200 hours or less, while 35 programs (15.3 percent) devoted more than 400 hours.

Teaching sites most commonly used for geriatrics training were the family practice center (96.4 percent), nursing home (87.9 percent), patients' home (81.9 percent), the family medicine inpatient ward (62.4 percent), and home care services (48.2 percent). Sites such as rehabilitation wards, hospices, and seniors centers were used by approximately 27 percent of the programs, whereas outpatient academic geriatric units, ambulatory geriatric clinics and inpatient geropsychiatric wards were each reported by less than 25 percent of the programs.

The distribution of time spent by residents of the different programs in the various teaching sites is presented in Table 1. More than half of the geriatrics teaching time was spent in the FPC (as reported by 22 percent of the programs) as compared with 15 percent for those who used nursing homes. In 107 programs (82 percent) less than 10 percent of their teaching time was devoted to home care services.

Of the 136 programs that used HCS as training sites, 132 directors rated their

TABLE 1

Percentages of 282 Family Practice Residencies Devoting Different Amounts of Time to Each of the Types of Sites for Geriatrics Training, 1987*

Teaching Site	Percentage of Time Spent		
	More Than 50	From 11 to 49	Less Than 10
Family practice center	22.1	72.1	5.7
Nursing home	15.7	49.6	34.7
Patient's home	0.4	14.3	85.3
Family medicine inpatient service	5.4	77.2	17.4
Home care service	0.0	17.7	82.3
Rehabilitation ward	1.4	33.3	65.3
Hospice	0.0	5.5	94.5
Seniors center	0.0	15.6	84.4
Geropsychiatric ward	0.0	36.8	63.1
Ambulatory geriatric clinics	8.6	51.7	39.6
Outpatient academic geriatric unit	22.5	42.5	35.0

TABLE 2

Numbers and Percentages of 136 Family Practice Residencies Using Home Care Services (HCS) as Geriatrics Training Sites That Used Each of Five Activities for Residents in the HCS Component, 1987*

Teaching Strategies	No.	Percent
No scheduled activities	28	20.5
Observes evaluation of patients performed by health professional	41	30.1
Performs only episodic interventions on patients	51	37.5
Performs evaluations and long-term follow-up of patients and has periodic discussions with attending physician	60	44.1
Performs evaluation and long-term follow-up of patients and has periodic discussions with multidisciplinary team	36	26.4

* The survey questionnaire was sent to all 380 U.S. family medicine residencies; 282 responded, and 136 of them used HCS sites for geriatrics training.

reasons for including HCS as teaching sites. They rated the importance of their reasons by a Likert-type scale, ranging from very important to not important at all. The questionnaire gave the respondents four possible reasons. Of these, the directors rated three as very important: the HCS provided good sites for teaching continuity of care (80 percent of the programs), for exposing trainees to the multidisciplinary team approach (76.5 percent), and for teaching cost-containment issues (48.4 percent).

Once in an HCS unit, a resident's activities varied in different programs. The percentages of programs with HCS training that used each of five teaching strategies is shown in Table 2. The two strategies used most frequently were having the resident perform evaluation and follow-up of patients and hold discussions with the attending physician (used by 44 per-

TABLE 3

Number of 53 Family Medicine Residencies That Evaluated Their Geriatrics Training Components in Home Care Service (HCS) and the Number and Percentage of These Components That Received High and Low Ratings, by the Teaching Strategy Used for the HCS Component, 1987

Teaching Strategies	No. of Programs	Ratings*			
		5 or Less		6 or More	
		No.	Percent	No.	Percent
No scheduled activities	9	3	33.3	6	66.6
Observes evaluation of patients performed by health professional	15	4	27.0	11	73.0
Performs only episodic interventions on HCS patients	29	6	21.0	23	79.0
Performs evaluation and long-term follow-up of patients and has periodic discussions with attending physician	20	4	20.0	16	80.0
Performs evaluations and long-term follow-up of patients and has periodic discussions with multidisciplinary team	20	2	10.0	18	90.0

* The survey questionnaire was sent to all 380 U.S. family medicine residencies; 282 responded. Of these, 136 used HCS sites for geriatrics training, and 53 of these evaluated their HCS components.

cent of the programs) and having the resident perform only episodic interventions on HCS patients (37.5 percent).

Forty-six percent of the respondents identified the attending physician as the professional most frequently in contact with residents during the HCS experience. Other professionals reported as also having close contact with the resident were registered nurses (47 programs) and social workers (23 programs). Also 43 programs reported contact between residents and home health aides. Professionals reported as having little or no contact with the resident were occupational therapists, physical therapists, and licensed practical nurses.

Of the 136 programs that used HCS, 53 (39 percent) had evaluated the HCS rotation by the time of the survey. These program directors were asked to rank the evaluations of the HCS experience as evaluated by the residents in their program. The overall evaluation ranking (on a range of 1 = poor to 10 = excellent) reported by the directors of these programs is presented in Figure 1.

The relationship between the activity of the residents performed in the HCS and the residents' evaluation of the rotation is presented in Table 3. The comparison of the residents' activities and their evaluation of the HCS component shows that (*a*) the programs providing no scheduled activities in the HCS component had the highest proportion of lower ratings (overall, ratings of five or less out of 10) and (*b*) the programs that used evaluations and follow-up of patients combined with periodic discussions between the resident and the multidisciplinary team had the lowest proportion of such lower ratings.

Discussion

Evaluating the physical and psychological constitution of an elderly patient and the patient's social and cultural environments requires skills that should be taught to all residents in primary care. This ger-

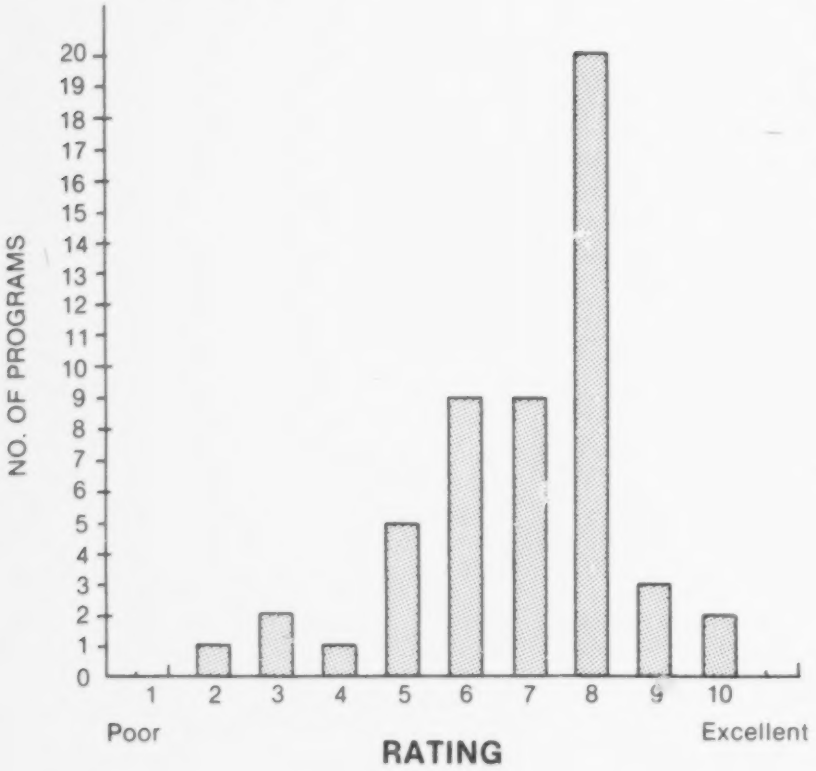

FIGURE 1

Ratings of home care services rotations offered by 53 family practice residencies in the United States that used such rotations, as reported by the program directors, 1987.

iatrics training should be presented in the most realistic context possible. Recent investigations show that, contrary to the general belief, most elderly persons (up to 95 percent) are not institutionalized (3). Indirect evidence indicates that medical care for this vast majority is deficient, as supported by facts such as a decline in the length of the patient-physician encounter as age increases, even though the elderly have multiple medical problems that are more complex than those of younger patients (2).

Historically, geriatric training in medical schools and postgraduate programs has emphasized the extremely ill, impaired, older patient in hospital settings and long-term care institutions such as nursing homes. These limited contacts between trainees and patients not only reinforce trainees' negative stereotypes and attitudes towards the elderly but also stress the concept of curative, episodic medicine, to the detriment of the preventive, continuing approach. Diseases common among the elderly—mild functional disabilities and other noncatastrophic conditions—are underemphasized.

Primary care physicians are responsible for most of the care of the elderly. General

practitioners and family physicians provide most of their nonhospital care (2). Most problems presented by the aged do not require exotic diagnostic and treatment protocols; rather, they are better approached by a multidisciplinary team, in coordination with the family and community groups.

The study presented here shows that most of the programs surveyed prefer the longitudinal and the combined (longitudinal and block) rotation formats. Block rotations, particularly those which emphasize hospitalized and institutionalized patients only, may prove to be deficient in providing the resident the necessary exposure to the healthy elderly living in the community.

A vast majority of the programs used the family practice center (FPC), nursing home, or patient's home, alone or in various combinations, as teaching sites. Of the 272 programs that reported using the FPC as a teaching site, 247 had the residents spend most of their time in this setting; only 6 percent reported using it less than 10 percent of the time. The programs using the rest of the most frequently used teaching sites (family medicine inpatient service, HCS, rehabilitation ward hospices, and senior centers), had residents spend less than 50 percent of their time in each site used.

In the past, the nursing home had been a classical teaching site for geriatrics in primary care (12). In the family medicine programs reported on here, the use of nursing homes was still very popular, both in frequency and in exposure time to the residents, as compared with other reported sites.

HCS were the fifth most frequently used teaching site in family medicine residencies, according to the present survey, but the amount of time that the resident spent in the HCS was very limited. Of the 136 programs using HCS as teaching sites, 82 percent reported having the residents spend only 10 percent or less of the total geriatric teaching time in the HCS. This finding is in clear contrast to the time spent at other rotation sites.

Recommendation

In order to assume the best and most integrated teaching of geriatrics it is essential to accept the following concepts. Short, isolated rotations through acute care facilities or long-term care institutions do not provide the right type of experience in continuity of care, common problems of the elderly, and socioeconomic factors affecting well-being and illness. Physicians trainees should have experiences in home, community, and ambulatory care settings such as HCS, FPCs, patients' homes, and geriatric day-care centers. These experiences will not only provide the opportunity for the trainees to see the elderly as productive individuals who can be free of diseases but also will teach about alternatives to institutionalization for the long-term care of the aged.

What can make HCS units more attractive or accessible as teaching sites to training programs in family medicine? The availability of HCS in the community and their accessibility to training programs may be major determinants. Nowadays changing health care policies promote the dispersion of HCS in almost every community. Training programs in family medicine must recognize the potential for education within an HCS. Health professionals who provide day-to-day care for the elderly can easily be part of the training team for residents. Every health professional may contribute significantly to a resident's training if specific and well-structured teaching objectives are provided. As noted in the present

survey, the HCS programs best ranked in resident evaluations were those in which the principal activity was the long-term follow-up of assigned patients and discussion of the patients' problems with a multidisciplinary team.

The combination of experiences in the HCS, FPC, and inpatient ward may prove to be an effective alternative to other methods of teaching geriatrics to residents. By coupling these clinical experiences with an integrated or parallel classroom component, family medicine programs can cover most of the recommended learning objectives for the geriatrics curriculum. These three training settings are readily accessible to most training programs and will certainly provide the training in continuity of care that is so important in primary care residencies.

In the family medicine inpatient ward, the resident would be able to learn about proper use of diagnostic tests, interpretation of diagnostic procedures, pharmacokinetics and pharmacodynamics in the aged, assessment and therapeutic interventions of common diseases in the elderly, including atypical presentations, psychiatric manifestations of organic diseases, and exacerbation of chronic illnesses.

The FPC would be the main site for teaching such aspects of geriatrics as drug-induced signs and symptoms, evaluative tools for cognitive function, special considerations in the diagnosis and treatment of multiple chronic problems in the elderly, preventive care, health maintenance, and nutritional assessment and treatment.

Home care services would be a rewarding teaching experience in understanding the principles of team management and interdisciplinary and multidisciplinary approach to health care, impact of the social environment on health and disease, implementation of rehabilitation protocols, appropriate use of community-based support systems for the elderly, home assessment of functional status of the elderly, risk analysis and accident prevention, recognition of the role of the caregiver and the stressors involved in the patient—care-giver relation at home, the role of intermediate care of the recently acutely ill patient, and the importance of discharge planning and its implementation. With the implementation of prospective payment systems and diagnosis-related groups (DRGs), early discharge of still sick patients is more the rule than the exception, and the physician trainee should have the diagnostic and intervention skills needed to manage these situations. Other inherent advantages that HCS provide are the opportunity to learn about family-interviewing skills, assessment of family dynamics and its implications in the care of the elderly, and the ability to obtain a holistic view of the aged within the context of their sociocultural milieu.

In the survey reported here, 91 (32.3 percent) of the 282 already had this three-part training. No data are available at present regarding the effectiveness of these combined settings in fulfilling the goals and objectives of geriatrics teaching. An interesting topic for future investigation would be the evaluation of those programs which use this combination. Also of interest would be the experience of other specialty training programs, such as internal medicine, regarding the use of HCS in their geriatrics curricula.

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